



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ELITE HEALTHCARE FORT WORTH

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-14-0776--01

Carrier's Austin Representative

BOX NUMBER: 19

MFDR Date Received

NOVEMBER 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Office Visit for the attached date of service 12/13/2012 has been denied to PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.. [sic] However, Per [sic] ODG office visits are recommended as determined to be medically necessary. Being this was the patient's initial visit and the doctor did a complete exam, which included Range of Motion and Motor Functions/Muscle strength also to include in this plan to order an XRay [sic] for further evaluation. This date should have been paid in full. I have attached all necessary documentation."

Amount in Dispute: \$274.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: NEW HAMPSHIRE INSURANCE CO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 20, 2012	CPT Code 99204	\$274.68	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.

3. 28 Texas Administrative Code §129.5 sets out the reimbursement guidelines for Work Status Reports

The services in dispute were reduced/denied by the respondent with the following reason codes:

- 18 – Exact duplicate claim/service.
- 476 - \$385.00 of the charges are duplicates of bill # 888-H-15359569-01..

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
2. Did the requestor meet the requirements of 28 Texas Administrative Code §129.5?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, “for coding, billing reporting, and reimbursement of professional medical services, Texas Workers’ Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided...” Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99214 is:

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Detailed History
 - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed two chronic condition, lumbar spine and right hip, thus, this component was not met.
 - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed one system, musculoskeletal, this component was not met.
 - Past Family, and/or Social History (PFSH) requires at least one specific item from any three history areas to be documented. The documentation did not list any past family or social history. This component was not met.
 - Documentation of a Detailed Examination:
 - Requires extended exam of affected area(s) and other symptomatic or related organ system(s), additional systems up to total of seven systems to be documented. The documentation found listed two body area/organ system, lumbar spine and right hip. This component was not met.
2. For the reasons stated above, the division concludes that the requestor has submitted insufficient documentation to support reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	July 31, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.